Complete Summary

GUIDELINE TITLE

Depression clinical practice guidelines.

BIBLIOGRAPHIC SOURCE(S)

Kaiser Permanente Care Management Institute. Depression clinical practice guidelines. Oakland (CA): Kaiser Permanente Care Management Institute; 2006 Mar. 196 p. [157 references]

GUIDELINE STATUS

This is the current release of the guideline.

This guideline updates a previous version: Kaiser Permanente Care Management Institute. Adult primary care depression guidelines. Oakland (CA): Kaiser Permanente Care Management Institute; 2004 Apr. 132 p.

To keep current with changing medical practices, all guidelines are reviewed, and if appropriate, revised at least every two years.

**** REGULATORY ALERT ****

FDA WARNING/REGULATORY ALERT

Note from the National Guideline Clearinghouse: This guideline references a drug(s) for which important revised regulatory and/or warning information has been released.

- May 2, 2007, Antidepressant drugs: Update to the existing black box warning on the prescribing information on all antidepressant medications to include warnings about the increased risks of suicidal thinking and behavior in young adults ages 18 to 24 years old during the first one to two months of treatment.
- October 25, 2006, Effexor (venlafaxine HCl): Published retrospective studies report that venlafaxine overdosage may be associated with an increased risk of fatal outcome.
- May 12, 2006, Paxil (paroxetine) and Paxil CR: Changes to the Clinical Worsening and Suicide Risk subsection of the WARNINGS section in the prescribing Information related to adult patients, particularly those who are younger adults.
- December 8, 2005, Paxil (paroxetine): Pregnancy category changed from C to D and new data and recommendations added to the WARNINGS section of prescribing information.

- September 27, 2005, Paxil (paroxetine) and Paxil CR: Changes to the Pregnancy/PRECAUTIONS section of the Prescribing Information to describe the results of a retrospective epidemiologic study of major congenital malformations in infants born to women taking antidepressants during the first trimester of pregnancy.

COMPLETE SUMMARY CONTENT

SCOPE

DISEASE/CONDITION(S)

Major Depressive Disorder

GUIDELINE CATEGORY

Management
Treatment

CLINICAL SPECIALTY

Family Practice
Internal Medicine
Nursing
Pharmacology
Psychiatry
Psychology

INTENDED USERS

Advanced Practice Nurses
Health Care Providers
Nurses
Pharmacists
Physician Assistants
Physicians

GUIDELINE OBJECTIVE(S)

To provide recommendations (evidence-based and consensus) on the treatment of Major Depressive Disorder in primary care adult outpatients

TARGET POPULATION

Adults with Major Depressive Disorder seen in primary care outpatient settings

Patients younger than 18 years and pregnant women are not included. These guidelines do not necessarily apply to adults being seen in specialty behavioral health (inpatient or outpatient) settings.

INTERVENTIONS AND PRACTICES CONSIDERED

Treatment/Management/Evaluation

1. Antidepressant treatment
    - Selective serotonin reuptake inhibitors (SSRIs)
    - Tricyclic antidepressants (TCAs)
    - Dopamine agonists (DAs)
    - Serotonin norepinephrine reuptake inhibitors (SNRIs)
    - Norepinephrine reuptake inhibitors (NRIs)
    - Combinations of antidepressants
2. Psychotherapy (interpersonal therapy, cognitive behavioral therapy, problem-solving therapy)
3. Combination of antidepressants and psychotherapy
4. Hypericum (St. John's Wort) (Note: Considered but not recommended)
5. Consultation with specialists (behavioral health, psychiatrist) for patients expressing suicidal ideation, intent, or plan
6. Second-line treatment for patients whose symptoms fail to remit
    - Combining antidepressants and psychotherapy
    - Increasing dose of antidepressant
    - Combined treatment with SSRI and low-dose desipramine
    - Switching to a different antidepressant
    - Augmenting with low-dose lithium
    - Switching from psychotherapy to antidepressants or vice versa

    Note: The following were considered but not recommended for second-line treatment: right prefrontal transcranial magnetic stimulation (rTMS), folate, inositol, vagus nerve stimulation, augmentation with atypical antipsychotic agents, augmentation with pindolol

7. Consideration of appropriate length of treatment with antidepressants
8. Follow-up at specified intervals, including assessment for adherence, side effects, suicidal ideation, and response to treatment
9. Tapering or stopping antidepressant medication
10. Consideration of patient treatment preferences
11. Self-management strategies, including exercise, bibliotherapy, internet self-help materials, and befriending
12. Behavioral health education classes

MAJOR OUTCOMES CONSIDERED

- Change in symptoms
- Quality of life
- Missed school/work days
- Office/Urgent Care Center(UCC)/Emergency Room (ER) visits
- Hospitalizations
- Mortality
- Adherence to treatment plan
- Patient satisfaction
- Relapse prevention
- Side effects of medication or adverse effects of treatment, such as attempted suicide

METHODOLOGY

METHODS USED TO COLLECT/SELECT EVIDENCE

Searches of Electronic Databases

DESCRIPTION OF METHODS USED TO COLLECT/SELECT THE EVIDENCE

Guidelines are developed using an "evidence-based methodology" and involve a systematic literature search, critical appraisal of the research design and statistical results of relevant studies, and grading of the sufficiency (quantity, quality, consistency, and relevancy) of the evidence for drawing conclusions.

During the guideline development process, the Guideline Development Team reviews evidence published in peer-reviewed scientific journals, existing evidence-based guidelines, and consensus-based statements from external professional societies and government health organizations, and clinical expert opinion of Kaiser Permanente regional specialty groups.

For details of the literature search, including databases searched and search terms for each clinical question, see the original guideline document.

NUMBER OF SOURCE DOCUMENTS

Not stated

METHODS USED TO ASSESS THE QUALITY AND STRENGTH OF THE EVIDENCE

Weighting According to a Rating Scheme (Scheme Given)

RATING SCHEME FOR THE STRENGTH OF THE EVIDENCE

Refer to Table 2 in the Appendix in the original guideline document for the system for grading the strength of a body of evidence.

METHODS USED TO ANALYZE THE EVIDENCE

Review of Published Meta-Analyses
Systematic Review with Evidence Tables

DESCRIPTION OF THE METHODS USED TO ANALYZE THE EVIDENCE

The Guidelines Project Management Team performed systematic reviews of the medical literature on each of the clinical questions identified by the workgroup.

METHODS USED TO FORMULATE THE RECOMMENDATIONS

Expert Consensus

DESCRIPTION OF METHODS USED TO FORMULATE THE RECOMMENDATIONS

To develop the Depression Guideline, a multidisciplinary, Programwide Depression Guideline Development Team (GDT) first met in August 2005 to define the scope of the guideline. The Project Management Team then performed systematic reviews of the medical literature on each of the clinical questions identified by the Guideline Development Team, assembled the evidence, and developed draft recommendations for review by the Guideline Development Team. All of the recommendations and supporting evidence were reviewed by the Guideline Development Team in depth through a series of conference calls in November through December 2005. GDT recommendations and supporting documents were then reviewed by the Quality Review Subcommittee (of evidence-based methodological experts) of the Kaiser Permanente National Guideline Directors group.

RATING SCHEME FOR THE STRENGTH OF THE RECOMMENDATIONS

Recommendations are classified as either "evidence-based (A-D, I)" or "consensus-based."

- Evidence-based: sufficient number of high-quality studies from which to draw a conclusion, and the recommended practice is consistent with the findings of the evidence. A recommendation can also be considered "evidence-based" if there is insufficient evidence and no practice is recommended.
- Consensus-based: insufficient evidence and a practice is recommended based on the consensus or expert opinion of the Guideline Development Team.

Label and Language of Recommendations*

Label	Evidence-Based Recommendations
Evidence-based (A)	**Language**: [a] The intervention is strongly recommended for eligible patients. **Evidence**: The intervention improves important health outcomes, based on good evidence, and the Guideline Development Team (GDT) concludes that benefits substantially outweigh harms and costs.

Label	Evidence-Based Recommendations
	Evidence Grade: Good.
Evidence-based (B)	**Language**: [a] The intervention is recommended for eligible patients. **Evidence**: The intervention improves important health outcomes, based on 1) good evidence that benefits outweigh harms and costs; or 2) fair evidence that benefits substantially outweigh harms and costs. **Evidence Grade**: Good or Fair.
Evidence-based (C)	**Language**: [a] No recommendation for or against routine provision of the intervention. (At the discretion of the GDT, the recommendation may use the language "option," but must list all the equivalent options.) **Evidence**: Evidence is sufficient to determine the benefits, harms, and costs of an intervention, and there is at least fair evidence that the intervention improves important health outcomes. But the GDT concludes that the balance of the benefits, harms, and costs is too close to justify a general recommendation. **Evidence Grade**: Good or Fair.
Evidence-based (D)	**Language**: [a] Recommendation against routinely providing the intervention to eligible patients. **Evidence**: The GDT found at least fair evidence that the intervention is ineffective, or that harms or costs outweigh benefits. **Evidence Grade**: Good or Fair.
Evidence-based (I)	**Language**: [a] The evidence is insufficient to recommend for or against routinely providing the intervention. (At the discretion of the GDT, the recommendation may use the language "option," but must list all the equivalent options.) **Evidence**: Evidence that the intervention is effective is lacking, of poor quality, or conflicting and the balance of benefits, harms, and costs cannot be determined. **Evidence Grade**: Insufficient.
Consensus-based	**Language**: [a] The language of the recommendation is at the discretion of the GDT, subject to approval by the National Guideline Directors. **Evidence**: The level of evidence is assumed to be "Insufficient" unless otherwise stated. However, do not use the A, B, C, D, or I labels which are only intended to be used for evidence-based recommendations. **Evidence Grade**: Insufficient, unless otherwise stated.
For the rare consensus-based recommendations which have "Good" or "Fair" evidence, the evidence must support a different recommendation, because if the evidence were good or fair, the recommendation would usually be evidence-based. In this kind of consensus-based recommendation, the evidence grade should point this out (e.g., "Evidence Grade: Good, supporting a different recommendation)."	

[a] All statements specify the population for which the recommendation is intended.

*Recommendations should be labeled and given an evidence grade. The evidence grade should appear in the rationale. Evidence is graded with respect to the degree it supports the specific clinical recommendation. For example, there may be good evidence that Drugs 1 and 2 are effective for Condition A, but no evidence that Drug 1 is more effective than Drug 2. If the recommendation is to use either Drug 1 or 2, the evidence is good. If the recommendation is to use Drug 1 in preference to Drug 2, the evidence is insufficient.

COST ANALYSIS

A formal cost analysis was not performed and published cost analyses were not reviewed.

METHOD OF GUIDELINE VALIDATION

Internal Peer Review

DESCRIPTION OF METHOD OF GUIDELINE VALIDATION

The National Guideline Directors' Guideline Quality Committee reviewed and approved the guidelines in March 2006.

RECOMMENDATIONS

MAJOR RECOMMENDATIONS

Recommendations are identified as either "evidence-based (A-D, I)" or "consensus-based." For definitions of the levels of recommendations see the end of the "Major Recommendations" field.

I. **First-Line Treatment Of Major Depressive Disorder (MDD)**

For patients with mild to moderate Major Depressive Disorder (MDD), use either antidepressant medication or psychotherapy[1] as first-line treatment.
Evidence-based

Given the lack of evidence on a clearly superior approach for mild to moderate MDD, treatment decisions should be based on patient and clinician preference, potential side effects, and cost.
Consensus-based

For patients with severe or chronic MDD, combined treatment with antidepressants and psychotherapy[1] is recommended as first-line treatment.
Evidence-based

If antidepressants are to be used, any class of antidepressant (selective serotonin reuptake inhibitor [SSRI], tricyclic antidepressant [TCA], serotonin

norepinephrine reuptake inhibitor [SNRI], norepinephrine reuptake inhibitor [NRI], or dopamine agonist [DA]) can be prescribed as first-line treatment of MDD.
Evidence-based

Given the equivalence of therapeutic effect, base the choice of antidepressant on patient's prior response, patient and clinician preference, potential side effects, and cost.
Consensus-based

II. St. John's Wort for MDD

For patients with mild to moderate Major Depression, there is insufficient evidence to recommend for or against hypericum as a treatment alternative. The evidence on hypericum (St. John's Wort) in mild to moderate Major Depression is conflicting and of questionable quality. The balance of benefits, harms, and costs compared with other treatments cannot be fully determined.
***Evidence-based* (I)[2]**

For patients with severe Major Depression, hypericum (St. John's Wort) is not recommended.
Evidence-based

III. Antidepressants In Patients With MDD Expressing Suicidal Ideation, Intent, Or Plan

For patients with Major Depression expressing suicidal intent or plan, consultation with specialty behavioral health is recommended.
Consensus-based

For patients with suicidal ideation or who have made previous suicide attempts, consult or collaborate with a psychiatrist before prescribing tricyclic antidepressants (TCAs) or venlafaxine.
Consensus-based

IV. Second-Line Treatment Of MDD

For patients with MDD whose symptoms fail to remit after first line treatment, assess adherence to the initial treatment regimen.
Consensus-based

For patients with MDD whose symptoms fail to remit after adherence to first-line treatment, second-line treatment options include:

- Combining antidepressants and psychotherapy. ***Evidence-based***
- Increasing the dose of the initial antidepressant. ***Consensus-based***
- Combined treatment with selective serotonin reuptake inhibitors (SSRIs) and low-dose desipramine (monitoring for TCA toxicity). ***Consensus-based***
- Switching to a different antidepressant of the same or different class. ***Consensus-based***

- Augmenting with low dose (300 to 600 mg/day) of lithium (in consultation with psychiatry). ***Consensus-based***
- Switching from psychotherapy to antidepressants or antidepressants to psychotherapy. ***Consensus-based***

For patients whose MDD symptoms fail to remit after adhering to first-line treatment, there is insufficient evidence to recommend the following treatments:

- Right prefrontal transcranial magnetic stimulation (rTMS).
- Folate
- Inositol
- Vagus nerve stimulation

***Evidence-based* (I)**

For patients with (non-psychotic) MDD whose symptoms fail to remit after adherence to first-line treatment, augmentation with atypical antipsychotic agents is not recommended.
Evidence-based

For patients with MDD whose symptoms fail to remit after adherence to first-line treatment, augmentation with pindolol is not recommended.
Evidence-based

V. Length Of Treatment With Antidepressants In Patients With MDD

Patients with MDD who achieve **symptom remission** with antidepressants should continue antidepressants at the same dose for at least an additional six to 12 months.
Evidence-based

Patients With One Lifetime Episode of MDD

Based on patient and provider preference, a trial of antidepressant discontinuation is optional for patients in their first lifetime episode of MDD, who are being treated with antidepressants, achieve remission, and remain asymptomatic for six to 12 months after acute phase treatment.
Consensus-based

Patients with Two or More Lifetime Episodes of MDD

Patients with two or more lifetime episodes of MDD, who are being treated with antidepressants and remain asymptomatic after acute phase treatment, should be maintained on the medication and dose with which they achieved remission for at least an additional 15 months to five years after acute phase treatment.
Consensus-based

Patients with Chronic MDD or MDD with concurrent Dysthymia

Patients with chronic MDD (continual symptoms for more than two years) or Double Depression (MDD and dysthymia) who improve with antidepressants during acute phase treatment should continue antidepressants for at least an additional 15 to 28 months after acute phase treatment.
Evidence-based

VI. Follow-Up For Patients In The First Three Months (Acute Phase) Of Treatment For MDD

For patients who are starting treatment with antidepressants for Major Depression, the minimum recommended follow-up frequency is one patient contact[3] within the first month, and at least one additional patient contact four to eight weeks after the first contact.
Consensus-based

Assess for adherence, side effects, suicidal ideation, and patient response during both these visits.
Consensus-based

Follow-Up For Asymptomatic Patients In Continuation Phase (Months Four To 12) Of Treatment Of MDD

After achieving symptom remission, at least one follow-up contact[4] is recommended during the fifth or sixth month of treatment in patients with Major Depression. Assess for continuing symptom remission and dosage/treatment adjustment during this contact.
Consensus-based

Additional patient follow-up is recommended to consider either continuing treatment beyond the continuation phase, or attempting a trial of treatment discontinuation.
Consensus-based

VIII. Follow-Up For Asymptomatic Patients With Major Depression In Maintenance Phase (Beyond 12 Months) Of Treatment Of MDD

For asymptomatic patients with Major Depression who are continuing on antidepressants beyond 12 months, at least one annual follow-up contact[5] is recommended to assess for continuing symptom remission, the need for ongoing treatment, and dosage/treatment adjustment.
Consensus-based

Additional follow-up for asymptomatic patients with Major Depression who are continuing on antidepressants beyond 12 months should be based on patient preference and response.
Consensus-based

IX. Discontinuation Of Antidepressants In Patients With MDD

Fluoxetine may be discontinued without tapering with a relatively low risk of adverse effects.
Evidence-based

Taper other antidepressants (other selective serotonin reuptake inhibitors, tricyclic antidepressants, serotonin norepinephrine reuptake inhibitors, norepinephrine reuptake inhibitors, or dopamine agonists) over a two to four week period.
Consensus-based

X. Treatment Preferences For MDD In Different Ethnic Groups

Because patient preferences for treatment may vary based on their ethnicity and culture, asking patients from different ethnic groups about treatment preference is recommended when discussing treatment options for MDD.
Evidence-based

XI. Patient Self-Management Strategies For Improving Depressive Symptoms In MDD

Exercise is recommended as an adjunctive strategy (in addition to antidepressants or psychotherapy) for treating the symptoms of MDD.
Consensus-based

Bibliotherapy is an optional adjunct strategy (in addition to antidepressants or psychotherapy) for treating the symptoms of MDD.
Consensus-based

Patient self-help materials on selected **internet**-sites[6] are an optional adjunct strategy (in addition to antidepressants or psychotherapy) for treating symptoms of MDD.
Evidence-based

Befriending is an optional adjunct to antidepressants or psychotherapy for treating the symptoms of MDD.
Consensus-based

Use of **automated telephone programs** is not recommended as adjunctive therapy for MDD.
Evidence-based

There is currently insufficient evidence to recommend **light therapy** as a primary or adjunctive treatment for non-seasonal forms of MDD.
***Evidence-based* (I)**

There is insufficient evidence to recommend for or against **music therapy** as an adjunct to antidepressants or psychotherapy for treating the symptoms of MDD.
***Evidence-based* (I)**

There is insufficient evidence to recommend for or against **life review therapy** as an optional adjunctive depression management strategy for depressed older adult patients who are concurrently receiving regular social services care.
***Evidence-based* (I)**

XII. **Behavioral Health Education Classes (Cognitive Behavioral Skills or Problem-Solving Classes) for Adults with MDD**

For patients with mild to moderate MDD, behavioral health education classes are an adjunctive treatment option, but should not be used in lieu of either antidepressant medication or psychotherapy.
Evidence-based

[1] (Interpersonal Therapy, Cognitive Behavioral Therapy, and Problem-Solving Therapy)

[2] Please note that only recommendations approved since the adoption in 2006 of evidence grading will use letters (A, B, C, etc.) to specify the grade of the evidence. Recommendations approved prior to 2006 will not include a letter grade following the statement "evidence-based." For additional information on evidence grading, see Table 1 on page 181 of the original guideline document.

[3] Contact may include in-person visits, phone calls or email between patient and clinician, or phone calls/email between patient and a care manager. The use of email between patients and providers is relatively new, and has not been a widely utilized means of communication to date. However, it is being increasingly advocated as part of a patient-centered, more efficient ("less visit dependent") model of care. At least one member of the Guideline Development Team uses this modality regularly and deems it effective for follow-up contacts.

[4] Contact may include in-person visits, phone calls or email between patient and clinician, or phone calls/email between patient and a care manager.

[5] Follow-up contact may include in-person visits, phone calls or email between patient and clinician, or phone calls/email between patient and a care manager. The use of email between patients and providers is relatively new, and has not been a widely utilized means of communication to date. However, it is being increasingly advocated as part of a patient-centered, more efficient ("less visit dependent") model of care. At least one member of the Guideline Development Team uses this modality regularly and deems it effective for follow-up contacts.

[6] Evidence at this time is limited to the following internet sites: Blue Pages, Mood GYM, and ODIN.

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Consensus-based	**Language**: [a] The language of the recommendation is at the discretion of the GDT, subject to approval by the National Guideline Directors. **Evidence**: The level of evidence is assumed to be "Insufficient" unless otherwise stated. However, do not use the A, B, C, D, or I labels which are only intended to be used for evidence-based recommendations.

Label	Evidence-Based Recommendations
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For the rare consensus-based recommendations which have "Good" or "Fair" evidence, the evidence must support a different recommendation, because if the evidence were good or fair, the recommendation would usually be evidence-based. In this kind of consensus-based recommendation, the evidence grade should point this out (e.g., "Evidence Grade: Good, supporting a different recommendation)."	

[a] All statements specify the population for which the recommendation is intended.

*Recommendations should be labeled and given an evidence grade. The evidence grade should appear in the rationale. Evidence is graded with respect to the degree it supports the specific clinical recommendation. For example, there may be good evidence that Drugs 1 and 2 are effective for Condition A, but no evidence that Drug 1 is more effective than Drug 2. If the recommendation is to use either Drug 1 or 2, the evidence is good. If the recommendation is to use Drug 1 in preference to Drug 2, the evidence is insufficient.

CLINICAL ALGORITHM(S)

None provided

EVIDENCE SUPPORTING THE RECOMMENDATIONS

TYPE OF EVIDENCE SUPPORTING THE RECOMMENDATIONS

The type of supporting evidence is not specifically stated for each recommendation, but the evidence underlying the recommendations are drawn from randomized controlled trials, meta-analyses, and existing systematic reviews. In cases where the data was inconclusive, inconsistent, or non-existent, recommendations were based on the consensus opinion of the group.

BENEFITS/HARMS OF IMPLEMENTING THE GUIDELINE RECOMMENDATIONS

POTENTIAL BENEFITS

Appropriate treatment and management of adult patients with Major Depressive Disorder

POTENTIAL HARMS

- Side effects of medication
- Adverse effects of treatment, such as suicide (attempted or completed)

CONTRAINDICATIONS

CONTRAINDICATIONS

Combining monoamine oxidase inhibitors (MAOIs) and selective serotonin reuptake inhibitors (SSRIs) have been associated with adverse patient outcomes and are contraindicated.

QUALIFYING STATEMENTS

QUALIFYING STATEMENTS

- These guidelines are informational only. They are not intended or designed as a substitute for the reasonable exercise of independent clinical judgment by practitioners, considering each patient's needs on an individual basis.
- Guideline recommendations apply to populations of patients. Clinical judgment is necessary to design treatment plans for individual patients.

IMPLEMENTATION OF THE GUIDELINE

DESCRIPTION OF IMPLEMENTATION STRATEGY

An implementation strategy was not provided.

IMPLEMENTATION TOOLS

Patient Resources
Resources

For information about availability, see the "Availability of Companion Documents" and "Patient Resources" fields below.

INSTITUTE OF MEDICINE (IOM) NATIONAL HEALTHCARE QUALITY REPORT CATEGORIES

IOM CARE NEED

Getting Better
Living with Illness

IOM DOMAIN

Effectiveness
Patient-centeredness

IDENTIFYING INFORMATION AND AVAILABILITY

BIBLIOGRAPHIC SOURCE(S)

Kaiser Permanente Care Management Institute. Depression clinical practice guidelines. Oakland (CA): Kaiser Permanente Care Management Institute; 2006 Mar. 196 p. [157 references]

ADAPTATION

Not applicable: The guideline was not adapted from another source.

DATE RELEASED

2004 Apr (revised 2006 Mar)

GUIDELINE DEVELOPER(S)

Kaiser Permanente Care Management Institute - Managed Care Organization

SOURCE(S) OF FUNDING

Kaiser Permanente Care Management Institute

GUIDELINE COMMITTEE

Kaiser Permanente Depression Guidelines Project Management Team
Kaiser Permanente Guideline Development Team

COMPOSITION OF GROUP THAT AUTHORED THE GUIDELINE

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FINANCIAL DISCLOSURES/CONFLICTS OF INTEREST

There were no conflicts of interest by the project management team or the guideline development team.

GUIDELINE STATUS

This is the current release of the guideline.

This guideline updates a previous version: Kaiser Permanente Care Management Institute. Adult primary care depression guidelines. Oakland (CA): Kaiser Permanente Care Management Institute; 2004 Apr. 132 p.

To keep current with changing medical practices, all guidelines are reviewed, and if appropriate, revised at least every two years.

GUIDELINE AVAILABILITY

Electronic and print copies: Available from Patricia deSa, Kaiser Permanente Care Management Institute, One Kaiser Plaza, 16th Floor, Oakland, CA 94612

AVAILABILITY OF COMPANION DOCUMENTS

The following are available:

- Kaiser Permanente Care Management Institute. Depression. Clinical practice guidelines for adult primary care. Oakland (CA): Kaiser Permanente Care Management Institute; 2006. 9 p.
- Kaiser Permanente Care Management Institute. Treating depression in primary care. Oakland (CA): Kaiser Permanente Care Management Institute; 2004. 2 p.

Electronic and print copies: Available from Patricia deSa, Kaiser Permanente Care Management Institute, One Kaiser Plaza, 16th Floor, Oakland, CA 94612

PATIENT RESOURCES

The following are available:

- Dealing with feelings of depression. Kaiser Permanente Medical Care Program. 2005.
- Talking with your health care provider about your antidepressant medication. Kaiser Permanente Medical Care Program. 2002.

Brochure ordering information: Available from the CMI Product Line at 510-271-6426, or CMIproducts@kp.org.

NGC STATUS

This NGC summary was completed by ECRI on December 6, 2004. The information was verified by the guideline developer on January 20, 2005. This

summary was updated by ECRI on August 15, 2005, following the U.S. Food and Drug Administration advisory on antidepressant medications. This NGC summary was updated by ECRI on September 28, 2006. The updated information was verified by the guideline developer on October 3, 2006. This summary was updated by ECRI on November 22, 2006, following the FDA advisory on Effexor (venlafaxine HCl). This summary was updated by ECRI Institute on November 9, 2007, following the U.S. Food and Drug Administration advisory on Antidepressant drugs.

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Readers with questions regarding guideline content are directed to contact the guideline developer.

Date Modified: 9/22/2008


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